ADATR

Missouri Division of Alcohol & Drug Abuse (ADA) SAMHSA Access to Recovery Grant (ATR)

RECOVERY SUPPORT SERVICES—CREDENTIALED STATUS APPLICATION

Instructions

- *Please type or print legibly and mail completed application to:* ***Division of Alcohol and Drug Abuse, ATR Project Director, 1706 E. Elm St., P.O. Box 687, Jefferson City, MO 65102*** ***PLEASE MAIL VIA "RETURN RECEIPT REQUESTED" IN ORDER TO OBTAIN PROOF AND DATE OF DELIVERY.***
- *Retain a copy of the completed application for your files.*
- *Questions can be directed to Committed Caring Faith Communities at (314) 951-1033 or the Division of Alcohol and Drug Abuse at (573) 751-4942.*

1. AGENCY IDENTIFICATION

ORGANIZATION NAME	DATE OF INCORPORATION WITH STATE OF MISSOURI
CONTACT PERSON REGARDING CREDENTIALING	TITLE

ADMINISTRATIVE SITE STREET CITY ZIP CODE COUNTY

ADMINISTRATIVE MAILING ADDRESS (IF DIFFERENT THAN ABOVE)

TELEPHONE NUMBER ( )	FAX NUMBER ( )	E-MAIL	WEBSITE

Please list any other program sites under item 9.

2. ADMINISTRATION

NAME OF ORGANIZATION'S LEADER OR DIRECTOR	TITLE (PASTOR, RABBI, IMAM, EXECUTIVE DIRECTOR, etc.)
YEAR ORGANIZATION WAS ESTABLISHED	ESTIMATED NUMBER OF ACTIVE CONGREGATION MEMBERS (IF APPLICABLE)
CURRENT NUMBER OF BOARD MEMBERS OR GOVERNING BODY MEMBERS	LIST NAMES OF ALL ADDICTION ACADEMY GRADUATES (ADD ATTACHMENT IF NESSECARY)
NUMBER OF INDIVIDUALS FROM ORGANIZATION WHO COMPLETED THE ADDICTIONS ACADEMY	
NAME OF PARENT CORPORATION (IF APPLICABLE)	

ADDRESS OF PARENT CORPORATION STREET CITY ZIP CODE

3. ATTACH ORGANIZATIONAL CHART, IDENTIFYING EACH ATR POSITION

4. TYPE OF APPLICATION

☐ INITIAL ☐ RENEWAL – CREDENTIALED STATUS EXPIRES ON _____.

5. TYPE OF ORGANIZATION LEGALLY RESPONSIBLE FOR THE OPERATION OF THE PROGRAM

FOR PROFIT:

☐ Partnership
☐ Corporation
☐ Limited Liability Corporation (LLC)
☐ Other *(specify):* _____

NOT-FOR-PROFIT:

☐ Corporation
☐ Limited Liability Corporation (LLC)
☐ Church-Affiliated
☐ Other *(specify):* _____

6. AGENCY REQUESTS CREDENTIALED STATUS FOR THE FOLLOWING RECOVERY SUPPORT SERVICES

Check all Recovery Support Services for which your organization is requesting credentialed status. (*See enclosed recovery support service definitions.)*

- ☐ Care Coordination
- ☐ Child Care
- ☐ Drop-In Center
- ☐ Emergency/Temporary Housing
- ☐ Family Engagement
- ☐ Pastoral Counseling
- ☐ Recovery Support-Individual
- ☐ Recovery Support-Group
- ☐ Spiritual Life Skills
- ☐ Transportation
- ☐ Work Preparation

Describe previous experience providing recovery support services

7. LIST NAMES OF STAFF OR VOLUNTEERS WHO WILL DELIVER EACH RECOVERY SUPPORT SERVICE AND ATTACH A RESUME OF EACH (ATTACH ADDITIONAL PAGE IF NEEDED)

NAME OF STAFF OR VOLUNTEER	QUALIFICATIONS	NAME OF RECOVERY SUPPORT SERVICES

8. PRINCIPAL GEOGRAPHIC AREA SERVED

9. LOCATION OF PROGRAM SITES (attach additional page as necessary)

PROGRAM NAME	ADDRESS STREET CITY ZIP	COUNTY	TELEPHONE NUMBER	FAX NUMBER	TYPE OF RECOVERY SUPPORTS OFFERED	DAYS/HOURS OPEN

10. ATTACH PROGRAM SCHEDULE INCLUDING HOURS OF OPERATION FOR THE SERVICES YOU WILL BE PROVIDING

11. ATTACH COPIES OF THE FOLLOWING—*As applicable to the services you will be providing*

- Inspection Report by a fire authority that the facility complies with the Life Safety Code of the National Fire Protection Association and local/state codes *(initial and renewal)*
- Occupancy and zoning permit
- Proof of Chauffeur's or CDL license and proper automobile insurance *(initial and renewal)*
- State of Missouri Certificate of Good Standing

12. ATTACH LETTERS OF SUPPORT/REFERENCE

13. INFORMATION SYSTEM REQUIREMENTS

- How many computers does the organization have? _____
- Does the organization have Internet access? _____
- Does the organization meet the minimum computer workstation requirements described below? _____

CATEGORY	REQUIREMENT
Operating System Version	*Windows XP Pro*
Computer Processor	450 Mhz or higher
Memory	256 MB or higher
Browser Version	Internet Explorer 6.0 or higher, with current service packs
Virus Protection	Required—Virus definitions must be kept current
Monitor	Capable screen resolution of 1024 x 768
Printer	Required for printing reports
E-mail	Internet e-mail address
Bandwidth	Fastest network connection available and economical to you—Recommend DSL or cable modem

(Agency Name) _____ hereby applies for Credentialed Status by the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse or Committed Caring Faith Communities as an ATR Recovery Support Program in accordance with applicable credentialing requirements. The agency agrees and understands that agents of the Division of Alcohol and Drug Abuse and/or Committed Caring Faith Communities may inspect the premises, review agency and personnel and client records, observe program operations, and interview employees and clients associated with the program(s). The agency agrees to comply with all written recommendations and requirements regarding compliance with credentialing requirements, as noted in reports issued by the Department of Mental Health, Division of Alcohol and Drug Abuse and/or Committed Caring Faith Communities.

SIGNATURE—CHIEF ADMINISTRATIVE OFFICER	DATE
SIGNATURE—GOVERNING BODY OR BOARD PRESIDENT	DATE

The Access to Recovery program is funded by a three-year grant from the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

RECOVERY SUPPORT SERVICES—DESCRIPTION OF PROGRAM

Briefly describe each recovery support service you plan to provide.

(This description must be typewritten and should not exceed the front and back of this form. However, an agency that operates multiple programs or program sites may submit a more lengthy description of its programs or a separate sheet for each program.)

SIGNATURE—CHIEF ADMINISTRATIVE OFFICER	DATE